September 13, 2010

Before the
Federal Communications Commission
Washington, D.C. 20554

In the Matter of:	)	
	)	
Rural Health Care Support Mechanism	)	GN Docket No. 02-60

REPLY COMMENTS OF NORTH CAROLINA OFFICE OF RURAL HEALTH AND COMMUNITY CARE – FCC NOTICE OF PROPOSED RULEMAKING (NPRM) IN THE MATTER OF RURAL HEALTH CARE SUPPORT MECHANISM

The North Carolina Office of Rural Health and Community Care (NC ORHCC) hereby submits its Reply Comments in response to the Federal Communications Commission's ("FCC" or "Commission") July 15, 2010 Public Notice of Proposed Rulemaking ("*Notice*" or "NPRM") in the above-referenced proceeding.[1] As part of the *Notice*, the FCC proposes and seeks comment on reforms to the universal service health care support mechanism that are consistent with the recommendations set forth in the National Broadband Plan to expand the reach and use of broadband connectivity for and by public and non-profit health care providers.

Our Office is vitally concerned about the ability of colleagues in the emergency medical services (EMS) community nationwide to access Universal Service Fund and related support to develop broadband and other telecommunications services in rural areas. We, therefore, wholeheartedly endorse the attached comments of the;

- National Association of State Offices of Rural Health (NOSORH)
- National Association of State EMS Officials (NASEMSO), and the
- National Rural Health Association (NRHA).

Sincerely,

Matthew Womble, MHA, EMT-P
Rural Hospital and EMS Specialist
North Carolina Office of Rural Health and Community Care
2009 Mail Service Center
Raleigh, NC 27699-2009

[1] *FCC Program to Expand Investment in Broadband Health Care Technology.* Public Notice, FCC 10-125 (rel. July, 15, 2010) ("*Notice*").

NOSORH
national organization of state offices of rural health

September 8, 2010

Commission's Secretary
Federal Communications Commission
445 12th Street SW
Room TW-A325
Washington, D.C. 20554

Re: **Comments-Notice of Proposed Rulemaking Rural Health Care Support Mechanism FCC 10-125 WC Docket No. 02-60**

To the Commissioners:

The National Organization of State Offices of Rural Health represents the country's fifty State Offices of Rural Health as they work to improve health and health care in rural America. All states maintain a State Office of Rural Health (SORH). SORH vary in size, scope, organization and services/resources provided, each SORH has a rich history of developing partnerships, creating programs and providing resources that help meet the healthcare needs of their rural citizens. These efforts include providing technical assistance and other support that rural communities and healthcare providers need to implement and utilize HIT initiatives. Examples of HIT-related SORH activity include:

1. Received funding from USAC to initiate the nation's first rural outreach efforts into rural America's health sector to promote applications for the original rural health discount program.
2. Two NOSORH representatives served consecutively on the USAC board. This membership allowed for healthy engagement of state offices of rural health in the USAC decision-making process, and generated national interest and involvement among state offices of rural health in the rural health discount program. Notably, the board membership no longer has rural organization membership, an omission that is addressed in our comments in Section X "Procedural Matters."
3. Led, staffed or provided technical assistance for FCC broadband projects across the nation.
4. Provide technical assistance to health care providers regarding meaningful use in conjunction with Rural Extension Centers.
5. Led or participated in gubernatorial HIT initiatives and statewide HIT activities.
6. Administered nearly $25 million in funding for HIT implementation in Critical Access Hospitals.
7. Conducted extensive HIT training sessions for rural healthcare providers over the past five years.

In forming its comments, NOSORH considered the needs of a wide range of health providers including safety net providers of all types, critical access hospitals, skilled nursing facilities and

emergency medical providers. In addition to soliciting comments from 50 SORH, NOSORH has consulted with small telco organizations, small rural health care providers and other national associations to formulate our comments. NOSORH supports the National Association of EMS Officials comments and encourages the FCC to further continue its efforts to address the technological issues of health care providers as they meet the needs of some of the most underserved Americans in the country.

The comments offered do not speak to all elements in the NPRM, but do reflect issues of importance to rural health care providers as recognized by the State Offices of Rural Health around the country. Comments respond to specific requests by the FCC for comment and are organized by the section number of the NPRM **FCC 10-125 WC Docket No. 02-60.**

For clarification, additional comment or questions, please contact our Director, Teryl Eisinger teryle@nosorh.org.

Sincerely,

Mark Schoenbaum, President

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SECTION III. HEALTH INFRASTRUCTURE PROGRAM

The FCC proposes to create a separate Health Infrastructure Program to subsidize up to 85 percent of construction costs of new regional or statewide networks that builds upon the Rural Health Care Pilot Program (RHCPP). NOSORH supports the FCC's intent on expanding broadband infrastructure to support health information exchange and innovative models of health care delivery that depend upon robust telecommunications and provides comments on each of the proposed process steps.

15. Initial application phase comment.

Comment: Clarify urban HCP eligibility for infrastructure program. The NPRM does not clearly state whether urban non-profit and public HCPs are eligible to participate in the infrastructure program as part of a dedicated health care network. The Rural Health Care Pilot Program recognized the importance of including urban providers in a network, providing that a majority of HCPs in the network were rural. Much of remotely-delivered health care is dependent upon rural HCP access to urban providers for receipt of telehealth services and health information. This deserves clarification, and inclusion of urban providers in a dedicated health care network is essential for access to services otherwise unavailable.

16. Project selection phase - comment on limiting the total number of projects that may be selected in given year and on prioritization rules to be applied by USAC in the event that funding requests exceed the annual amount available under the health infrastructure program.

Comment: The Commission should develop objective application scoring criteria for predicting successful, sustainable network projects. The FCC noted in its comments that some of the Pilot projects were ill prepared and that a smaller amount of projects would allow USAC to devote greater resources to ensure success. We concur. The Pilot project did not go far enough in evaluating the projected success of each application prior to funding announcements. Instead, projects were subject to an open-ended examination of their sustainability, which caused significant delays and undue burden to existing projects. Predicted success and sustainability must be part of any thorough application review. Furthermore, program requirements should be spelled out in advance, not during the implementation process. Applications scoring criteria should include clear project goals, evidence of sustainability and demonstrated organizational, business, financial and technical capacity. Those failing to meet the scored criteria should receive feedback, if possible, and have an opportunity to reapply for funding in subsequent years. This early scrutiny will serve not only the FCC in ensuring the success of funded projects through targeted technical assistance, but will also assist those projects that do not meet the funding criteria to identify areas of improvement for future successful re-application.

17. Comment on Project commitment phase.

Comment: We support verification of the agreements to comply with program requirements specifically related to contribution requirements. The Commission itself notes that the Rural Health Care Pilot Program has learned that applicants have difficulty in meeting a 15 percent requirement. The health care infrastructure program proposes to serve a disadvantaged group of health care providers to provide safe, accessible health care. We support a fifteen percent direct HCP contribution which will allow for in-kind contributions related to the infrastructure development. This is attainable for most rural HCPs and yet requires participants to have a financial stake in the success of the network.

20. <u>Should the Commission set a minimum threshold for broadband connectivity speeds under the health infrastructure program?</u>

Comment: The proposed minimum broadband speed of 10 Mbps requirements for infrastructure projects may be unattainable for some rural health care providers; a more flexible approach is encouraged. Modifying the FCC's current definition of broadband (768Kbps) is appropriate and aligns with recommendations in the National Broadband Plan. The plan, however, recognizes the varying requirements for types of health care providers, citing 4Mbps as appropriate for a small physician office, and increasing according to size of facility and type of health care provided. Requiring 10 Mbps for any provider attempting to participate in a networked solution may exclude certain rural or small providers. Setting standards for the industry while maintaining flexibility, in accordance with the type of provider, may be necessary to ensure broad participation and access. We support minimum standards for Quality of Service and latency as a component of any competitive bid. A required standard for latency of 10 milliseconds should be an expectation.

47. The FCC seeks comment on eligible sources for matching funds.

Comment: The commission proposes placing limitations on the eligible sources for matching funds, with limitations to eligible health care providers in particular who do not demonstrate that 15 percent contribution is derived from a cash source.

In rural and frontier areas of the country in which the Commission supports grants to expand broadband infrastructure, consideration should be given to recurring charges that will be imposed by the telecommunications industry on the health care providers. Some rural health recipients of the current pilot program were unable to implement their approved program when they learned that they were unable to afford either the 15 percent cash match, or the recurrent charges that would be imposed by the telecommunications company for ongoing services.

The 15 percent cash match policy should be modified to allow for a mix of cash and in-kind match for recipients of the expanded pilot program.

SECTION IV. BROADBAND SERVICES PROGRAM

93. <u>Fifty percent subsidy proposal</u>

Comment: A flat 50 percent subsidy would significantly disadvantage remotely rural health care providers that need it most. The NPRM is unclear as to whether the health broadband services program will replace both of the current telecommunications and internet access programs or only the internet program.

We recognize that many eligible rural health providers do not currently apply for the current rural health telecommunications discount, and believe in many cases; the reason is that they believe the staff effort required for the initial application is not worth the financial gain.

The 50 percent subsidy should be increased to at least 65 percent, thus providing a more realistic incentive for applications. The demand increase will inevitably result in the aggregate annual cap of $400m for the Rural Health Care Support Mechanism being reached quickly, leaving in its wake administrative challenges for prioritizing funding in the event that qualifying projects collectively exceed the legislative cap.

97. Minimum level of broadband capability.

Comment: A minimum 4Mbps broadband speed should not prevent rural HCPs from participating in the program. In keeping with the recommendation of the National Broadband Plan and supporting a goal of overall broadband development to support health care, 4Mbps is an appropriate minimum standard. However, there are concerns about whether small rural HCPs would be unable to access the recommended minimum due to unavailability and would therefore become ineligible for subsidy. There are still HCPs in rural areas that struggle to get a 1.5Mpbs connection due to limitations of local service providers and disinterest on the part of larger providers. Rural HCPs with limited broadband access should not be required to bear the cost of service provider upgrades in order to participate in the broadband services program.

SECTION V. ELIGIBLE HEALTH CARE PROVIDERS

115. Should the FCC expand the specific facilities that can be funded, consistent with the current statute, are there are any providers not identified that should be eligible for support?

Comment: As hospitals, medical specialists, and other sources of specialty and general medical care decline in number in rural areas, EMS providers are increasingly called upon to help address those gaps, becoming integral in more areas than just emergency response in the delivery of care. They have to transport an increasing number of patients to medical centers ever further away and to provide a higher level of care during those extended episodes of care and transport.

NOSORH is pleased that the FCC has included "ambulance services" in Paragraph 8 of its Initial Regulatory Flexibility Analysis ("IRFA"), included in this NPRM. We assume that this reflects an intention on the Commission's part to include EMS in its enablement of rural health care broadband development. However, that the Commission makes no specific reference in the body of the NPRM itself to EMS agencies (ambulance and non-transporting emergency medical services, and EMS agencies providing community paramedicine or other similar primary care services) as eligible health care providers for the purposes of this proceeding and rules. This leaves to interpretation whether or not such EMS agencies are included as "local health agencies" and qualify for the benefits provided.

Emergency medical services may be operated by a variety of entities and under one of many business arrangements. For example, an ambulance service (or non-transporting first responder service, or community paramedicine service) may be a part of a hospital or clinic, a fire department or police agency, or may be an independent volunteer or commercial agency. It may operate under a non-profit, public utility, governmental or for-profit business model. These considerations have led, anecdotally, to interpretations that EMS agencies should not benefit from Federal government provisions afforded others. Regardless of any of these considerations, EMS agencies serve local citizens and governments in an ever-broadening role as 9-1-1 responders/long distance patient care and transport providers/primary care providers in rural health settings, and should be interpreted by the FCC as a *local health agency* to qualify for the broadband benefits of these provisions.

Non-profit Home Health Agencies that show evidence of patient use of electronic patient health records (PHR) should be considered eligible for the Rural Health Care Support Mechanism. Insufficient broadband capacity in many rural and frontier areas of the country prevent implementation of tele-home health care services that can save lives as well as money by

reducing extensive travel time on the part of agency care-givers. While the proposed FCC initiative will expand broadband into remote areas of the country, it may not generate sufficient demand so as to create a critical mass of users to make the system build-out and related investment cost-effective. To that end, we believe that adding non-profit home health agencies that can show evidence of exchanging electronic patient health records with their patients should be considered eligible.

116. Eligibility for Off-Site administrative offices.

Comment: Off-site administrative offices should be allowed to participate in the Rural Health Care Support Mechanism, so long as legal proof is provided showing ownership or controllership by the eligible rural health providers. We agree that a 51 percent rule governing ownership should be applied.

125. Skilled nursing facility eligibility in the Rural Health Care Support Mechanism?

Comment: The Commission should NOT adopt a certificate of need policy as one of the eligibility requirements for skilled nursing facilities. Not all states require certificates of need. Such a ruling would unfairly discriminate against those states without a certificate of need policy.

We recommend that designation of a skilled nursing facility be based on the number of patients at a facility that received skilled nursing services over a three-month period of time compared to the total number of patients at the facility for the same period of time.

SECTION VI. ANNUAL CAPS AND PRIORITIZATION RULES

128. Aggregate Annual Cap

Comment: To ensure continued rural parity in discount distribution to rural health providers we recommend that funds set aside for the proposed broadband grant program be reduced from $100 million (out of the $400 million) for infrastructure projects under the health infrastructure program to $50 million.

134. Competitive process

Comment: We do not recommend that the Commission set aside funding for a competitive process that demonstrates innovative uses of broadband connectivity to meet health care needs in a community. Our reason for this recommendation is simple. Rural health care providers often do not have staff capacity to write competitive grants, or funds to hire expensive grant writers who will write successful proposals in their behalf. Rural Health Support Mechanism funds should support an increased telecommunications discount for rural health providers.

130. Eligible health care providers based on their HPSA score.

Comment: NOSORH supports a prioritization methodology for funding, but question the use of HPSAs in the prioritization; rather, a measure of rurality or remoteness of rural sites should be considered as a third-tier prioritization. We support the first two tiers of priorities: 1) total number of rural HCPs in proposed network; 2) total number of HCPs (both urban and rural). However, use of a HPSA score for urban providers is not an appropriate tool. Urban providers in

a rural-urban network are likely to be medical centers or specialty clinics delivering care to remote sites; HPSA scores for these type of providers would not address need as much as consideration of remoteness or low density often experienced by rural health care providers in frontier regions.

SECTION IX. DATA GATHERING AND PERFORMANCE MEASURES

143. Should the Commission align its performance measures with HHS's meaningful use criteria?

Comment: We agree with the Commission's proposition that the adoption of performance measures will enhance the Commission's capacity to evaluate the extent to which expanded Broadband access will improve health care. However, we recommend that the Commission **NOT** require health care providers to provide such measures directly to the Commission or to USAC.

Current studies show that rural health care providers have fallen behind their urban counterparts for current reporting of measures into the Hospital Compare program, largely due to lack of funds and trained personnel to track and report data. The studies further reveal that the number of clinical cases documented by many small rural hospitals is too low to show any meaningful use progress. These issues should be resolved by HHS prior to the Commission's adoption of a meaningful use reporting requirement to the Commission or USAC.

When and if the Commission adopts meaningful use requirements, the Commission should enter into a data sharing agreement with federal agencies such as the Department of Health and Human Services, Department of Commerce, and Department of Agriculture. Such an agreement will prevent double reporting, and be more cost effective for rural health care providers that are already reporting performance measures to federal agencies. This alignment will enable the Commission to access meaningful use data already reported and recorded by federal agencies.

145. Performance criteria.

Comment: We recommend adoption of the American Telemedicine Association's Standards and Guidelines for Tele dermatology, Tele mental Health and Tele pathology as an acceptable methodology for evaluating the effectiveness of Broadband utilization for medical services.

The Commission should also consider how advances in rural/rural, rural/urban health information exchange can be addressed as performance criteria.

146. Should the Commission require each program beneficiary to identify more specific performance measures?

Comment: Rural beneficiaries in particular will be able to offer different and creative ways of identifying their own performance measures. The measures they provide will offer useful information for innovative evaluation purposes, and the development of successful models for future replication and funding.

148. Examining the extent to which training will led to better broadband utilization and improved care.

Comment: Many rural health care providers currently provide telehealth services using existing telecommunications infrastructures. Some of the rural health care providers have immediate

access to sophisticated telehealth technology that their providers do not use. Many rural health providers currently do not apply for or receive USAC discounts for which they are eligible. The Commission should make funding available for training that will not only enable better broadband utilization, but show progress in using telemedicine systems that are in place as a result of the expanded broadband mechanisms.

149. Should the Commission allocate a portion of the rural health care funding for running trials of and evaluating innovative concepts, and if so, what amount should be set aside for that purpose?

Comment: We agree that evaluating innovative concepts is a worthwhile idea, and that funding should be set aside for this purpose, not on a permanent basis, but over a five-year trial period. The Rural Health Research Centers, funded by the Office of Rural Health Policy, HHS/HRSA, should be given priority as evaluators, as they bring extensive rural health experience and knowledge of the concepts addressed by the Commission in this ruling.

SECTION X. PROCEDURAL MATTERS

NOSORH recommends that the Rural Health Support Mechanism administrative program (the Universal Services Administrative Corporation or its equivalent) be required by the Commission to include on its board representation from a national rural health organization such as the National Organization of State Offices of Rural Health in order to more effectively generate collaborative efforts with rural constituencies.

National Association of State EMS Officials
201 Park Washington Court Falls Church, VA 22046-4527 www.nasemso.org
703-538-1799 fax 703-241-5603 info@nasemso.org

September 7, 2010

Before the
Federal Communications Commission
Washington, D.C. 20554

In the Matter of:	)	
	)	
Rural Health Care Support Mechanism	)	GN Docket No. 02-60

COMMENTS OF THE NATIONAL ASSOCIATION OF STATE EMERGENCY MEDICAL SERVICES OFFICIALS – FCC NOTICE OF PROPOSED RULEMAKING (NPRM) IN THE MATTER OF RURAL HEALTH CARE SUPPORT MECHANISM

The National Association of State Emergency Medical Services Officials (NASEMSO) hereby submits its Comments in response to the Federal Communications Commission's ("FCC" or "Commission") July 15, 2010 Public Notice of Proposed Rulemaking ("*Notice*" or "NPRM") in the above-referenced proceeding.[1] As part of the *Notice*, the FCC proposes and seeks comment on reforms to the universal service health care support mechanism that are consistent with the recommendations set forth in the National Broadband Plan to expand the reach and use of broadband connectivity for and by public and non-profit health care providers.

Our Association is a leader in the national emergency medical services (EMS) community and in EMS system development. This is also true in the world of public safety communications in which NASEMSO staff also serves as communications technology advisor to other national EMS associations, assuring a national EMS community voice in this arena.

[1] *FCC Program to Expand Investment in Broadband Health Care Technology.* Public Notice, FCC 10-125 (rel. July, 15, 2010) ("*Notice*").

On behalf of that national EMS community, NASEMSO has submitted comments on the necessity for public safety broadband network development in general, and its critical role in the future delivery of EMS specifically, particularly in rural areas, in previous proceedings[2, 3, 4]. We ask that these previous submissions be considered as a foundation for the comments herein.

Our Association's particular interest in this filing is replying to the Commission's request in Paragraph 115 of the NPRM seeking "comment on whether there are any providers not identified below that should be eligible for support, consistent with the provisions of section 254(h)(7)(B)".

NASEMSO strongly supports the FCC's intention, in its National Broadband Plan as stated in Paragraph 114 of the NPRM, to re-examine its interpretation of 47 U.S.C. § 254(h)(7)(B) "in light of trends in the delivery of health care, and expand the definition of health care providers to include, where consistent with the statute, those institutions that have become integral in the delivery of care in the United States." We believe that EMS agencies are increasingly integral to more than just emergency health care delivery, and that they should benefit from the provisions in question and be specifically cited by the Commission as eligible health care providers. They should be interpreted specifically as eligible under the definition of "local health agencies" as now listed in 47 U.S.C. § 254(h)(7)(B).

[2] Comments of NASEMSO submitted on 11/12/09 in response to *Additional Comment Sought on Public Safety, Homeland Security, and Cybersecurity Elements of National Broadband Plan; NBP Public Notice # 8.* Accessed 9/5/10 at: http://www.nasemsd.org/Projects/CommunicationsTechnology/index.asp

[3] Comments of NASEMSO submitted on 12/1/09 in response to *Comment Sought on Public Safety Issues Related to Broadband Deployment in Rural and Tribal Areas and Broadband Communications to and from Persons with Disabilities – NBP Public Notice #14, Public Notice, DA 09-2369 (rel. Nov. 2, 2009) ("Notice").* Accessed 9/5/10 at: http://www.nasemsd.org/Projects/CommunicationsTechnology/index.asp

[4] Comments of NASEMSO submitted on 12/3/09 in response to *Comment Sought on Health Care Delivery Elements of National Broadband Plan – NBP Public Notice #17*, Public Notice, DA 09-2413 (rel. Nov.12, 2009) ("*Notice*"). Accessed 9/5/10 at: http://www.nasemsd.org/Projects/CommunicationsTechnology/index.asp

As hospitals, medical specialists, and other sources of specialty and general medical care decline in number in rural areas, EMS providers are increasingly called upon to help address those gaps, becoming integral in more areas than just emergency response in the delivery of care. They have to transport an increasing number of patients to medical centers ever further away and to provide a higher level of care during those extended episodes of care and transport. They are also likely candidates to develop primary care support services, in a community paramedicine or other practice setting, to augment rural clinic, home nursing and other traditional services that become overwhelmed by the loss of hospitals and other services. To carry out these services, as explained in the previous NASEMSO broadband filings cited above, EMS providers will increasingly become dependent on broadband to link them with physicians for clinical oversight and assistance, as well as for situational awareness to most efficiently coordinate and target scarce and distant response resources.

According to Paragraph 115 of the NPRM, 47 U.S.C. § 254(h)(7)(B) defines "health care provider" as: "(1) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (2) community health centers or health centers providing health care to migrants; (3) local health departments or agencies; (4) community mental health centers; (5) not-for-profit hospitals; (6) rural health clinics; and (7) consortia of health care providers consisting of one or more entities described in clauses (1) through (6)".

Our Association is pleased that the FCC has included "ambulance services" in Paragraph 8 of its Initial Regulatory Flexibility Analysis ("IRFA"), included in this NPRM. We assume that this reflects an intention on the Commission's part to include EMS in its enablement of rural health care broadband development. We are concerned, however, that the Commission makes no

specific reference in the body of the NPRM itself to EMS agencies (ambulance and non-transporting emergency medical services, and EMS agencies providing community paramedicine or other similar primary care services) as eligible health care providers for the purposes of this proceeding and rules. This leaves to interpretation whether or not such EMS agencies are included as "local health agencies" and qualify for the benefits provided.

Emergency medical services may be operated by a variety of entities and under one of many business arrangements. For example, an ambulance service (or non-transporting first responder service, or community paramedicine service) may be a part of a hospital or clinic, a fire department or police agency, or may be an independent volunteer or commercial agency. It may operate under a non-profit, public utility, governmental, or for-profit business model. These considerations have led, anecdotally, to interpretations that EMS agencies should not benefit from Federal government provisions afforded others. Regardless of any of these considerations, EMS agencies serve local citizens and governments in an ever-broadening role as 9-1-1 responders/long distance patient care and transport providers/primary care providers in rural health settings, and should be interpreted by the FCC as a *local health agency* to qualify for the broadband benefits of these provisions.

The future of EMS communications is broadband. Fast, robust data communications will enable EMS professionals to have a level of situational awareness (a real-time understanding of all events and resources impacting response, patient care, and transport) not possible today. In this way, the use of video, patient monitoring and other data transmissions will serve life-threatened patients, patients being transported long distances, and patients receiving primary care in community EMS primary care programs. The aging VHF, UHF, and trunked systems used by

EMS for the past 40 years will not support these data communications. EMS agencies must be eligible to receive rural broadband funding to develop these systems.

Respectfully Submitted,

Steven Blessing, President

National Association of State EMS Officials

201 Park Washington Court

Falls Church, VA 22046-4527

703-538-1799

NATIONAL RURAL HEALTH ASSOCIATION

Administrative Office 521 East 63rd Street Kansas City, Missouri 64110-3329 Telephone: [816] 756.3140 FAX: [816] 756.3144 **Government Affairs Office** 1108 K Street NW, Second Floor Washington, DC 20005-4094 Telephone: [202] 639.0550 FAX: [202] 639.0559 **www.RuralHealthWeb.org** September 8, 2010

Julius Genachowski, Chairman
Commissioners Copps, McDowell, Clyburn, Baker
Federal Communications Commission
445 12th Street SW Washington, DC 20554

Subject: Federal Communications Commission Notice of Proposed Rulemaking - Rural Health Care Support Mechanism, WC Docket No. 02-60 2

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Introduction and Summary

The National Rural Health Association (NRHA) is pleased to offer comments on the Federal Communications Commission (the Commission) notice of proposed rulemaking (NPRM) relating to its Rural Health Care Support Mechanism. We appreciate your commitment to improving rural America's broadband access, and look forward to our collaboration to ensure our mutual goals are met.

The NRHA is a non-profit membership organization with more than 21,000 members nation-wide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care infrastructure, from hospitals to individual patients. We work to improve rural America's health needs through government advocacy, communications, education and research.

Rural American health providers face significant barriers in access to a robust broadband network. Lack of financial incentives and access to capital, coupled with long distances between sites, contributes to a system in which rural providers are in danger of being left behind in the digital divide. In contrast, the benefits of broadband and a fully integrated health information technology (health IT) system have the potential to address many of rural America's current health care hurdles. Therefore, bringing the critical underlying broadband technologies to rural America is of the utmost importance.

Narrowing this access gap in rural America will require a robust health IT system that brings together the multitude of technological needs, such as electronic health records, telemedicine, and other health IT components. The underlying broadband capacity is necessary to transfer large EHR files, run telehealth services, monitor and develop assistive technologies, and to keep up with other emerging health technologies.

For this reason, we believe this notice of proposed rulemaking (NPRM) represents a significant step forward in ensuring rural health providers are able to keep up with the latest technological needs required to provide patient care. This letter outlines suggestions, however, to improve its overall reach to ensure these programs truly reach those intended.

First, we discuss the Commission's proposed **Health Infrastructure Program**, which we believe to be a step in the right direction assuming certain improvements are implemented. First, we urge the Commission to increase its efforts to foster interagency collaboration between itself and other federal agencies with similar programs and goals. Additionally, while we believe the Commission's plan to provide up to 85 percent of the associated costs would assist many health providers, we are concerned that many in rural areas will struggle to match the extra 15 percent requirement. Therefore, we suggest the Commission reduce this threshold for the rural providers most in need, and to also allow in-kind contributions to count as eligible costs under this requirement. Finally, because of staffing difficulties rural providers struggle with as it is, we are concerned that many providers will face 4

significant burdens with navigating the complicated application and administrative process associated with this program. Many rural health providers, though eligible, will not receive benefits simply due to the associated paperwork and filing requirements set forth in this NPRM.

We are pleased with the Commission's proposed plan for its **Broadband Services Program** that will replace the current Internet Services Program, but also provide suggestions to improve its reach to rural American health providers. First, we suggest that, while the Commission's plan to implement a minimum broadband speed of 4 megabits per second represents a needed goal, it should not be a minimum requirement for eligibility.

Additionally, we appreciate the Commission's proposal to increase its level of support within this program, but also urge it to recognize the unique challenges faced by rural providers and set a minimum level of equal to 60 percent of providers' recurring costs. We also urge the Commission to consider eligible providers within this program regardless of whether or not they have participated in the previous Rural Health Care Pilot Program, or to assist such providers with their internet costs.

The NRHA urges the Commission to recognize the unique difficulties rural providers will face in meeting the Centers for Medicare and Medicaid Services (CMS) **Meaningful Use guidelines**, and therefore not align any eligibility criteria within this NPRM's proposed programs with them. A fully implemented electronic health record (EHR) assumes an underlying broadband network is already in place, and while we recognize the importance of aligning the two programs as an ultimate goal, their eligibility requirements should not be interconnected. Instead, we urge the Commission to align this NPRM's proposed programs with the concept of a health information exchange (HIE), as well as develop an evaluation form that elicits information on how broadband services are used by individual providers in various rural areas.

We appreciate the Commission's willingness to revisit its interpretation of **eligible providers**, and willingness to accept comments on further expanding this list. We suggest that additional providers, such as emergency medical service (EMS), home health and additional mental health providers be included as well. Additionally, because for-profit providers are the only place to turn in many rural areas, we urge the Commission use its authority to group certain rural for-profit providers into the same category as public or non-profit health providers.

We look forward to any further collaboration ensuring the one-quarter of Americans living in rural America have access to the broadband services, and therefore the health providers, they need. 5

Health Infrastructure Program

The Commission's proposed Health Infrastructure Program is intended to support up to 85 percent of the installation, construction or setup costs of new regional or statewide broadband networks for public and non-profit health care providers in rural or other areas where current broadband capacity is insufficient. The Commission estimates somewhere between 6 to 8 projects would be funded as part of this program, with a ceiling of $100 million per year of available funding.

The NRHA is supportive of this proposed program's overall goal of providing the necessary broadband capacity to health providers in areas with limited or no broadband access. The NRHA is concerned, however, that this current proposal, while well intentioned, could fall short of its stated goals.

We are notably concerned with the idea that this program would require health providers to be in the business of telecommunications construction, thus putting them in direct competition with companies actually set up to do so.

Additionally, we are concerned with the Commission's projection that this program will fund 6 to 8 large health network centers. Though we understand the importance of providing larger systems with broadband capacity that could in turn reach out to smaller rural providers, we would argue that increasing the total number of award recipients would better help ensure its success.

The NRHA has the following concerns and/or suggestions for improvement within this proposed program:

Health Providers as Commercial Telecommunications Providers

Health care providers are not, nor should they be, in the business of providing telecommunications connections to their surrounding communities. The NPRM's proposed broadband infrastructure program, however, would force health providers to compete with companies specifically set up to provide such services at the commercial level. In rural America, where providers are struggling as it with the current health care workforce shortage and lack of access to capital, this would only be compounded. 6

85 Percent as a Floor, Not a Ceiling

While we believe any support offered by this program would be beneficial, rural providers are not likely to find even minimal costs achievable. The Commission itself notes in the NPRM that in the Rural Health Care Pilot Program, "some applicants have difficulty even meeting a 15 percent contribution requirement." The NPRM, however, asks for comment on whether or not a higher provider contribution requirement should be considered, and states this could help increase the total number of program participants. We would argue, however, that rising this contribution requirement would mean less providers would qualify in the first place, thereby actually reducing the total number of applicants. So while we believe that providing an 85 percent of infrastructure costs would help some providers, many in rural areas would still have difficulty matching even a 15 percent threshold.

Therefore, we would first urge the Commission to set a floor of 85 percent to ensure that no rural provider receives any less than 85 percent of the installation, construction or setup costs of new regional or statewide broadband networks.

Additionally, we urge the Commission to adopt a system in which a sliding scale of need is adapted to determine a provider's required match within the extra 15 percent required.

In-Kind for 15 Percent Threshold

As part of its minimum participation contribution requirements, the NRPM proposes to require eligible providers certify their ability to provide at least 15 percent of the funding required for the costs associated with its infrastructure program. As stated above, and also stated by the Commission in this NPRM, rural health providers will have problems affording even matching 15 percent of this program's associated costs. If providers were able to count in-kind, or non-financial, contributions related to the necessary components set forth in this infrastructure program, however, their ability to qualify may be more achievable.

Administrative Burdens

As many of the current and former recipients of the Rural Health Care Pilot Program will proclaim, the administrative burdens placed on rural providers who are already faced with significant difficulties finding and affording staff are daunting. Therefore, the NRHA is concerned that this new proposed infrastructure program will place similar or even greater burdens on rural providers who may not have the staff capacity to simply perform the heavy paperwork requirements required to qualify. With rural providers often struggling to merely keep their doors open, impossible administrative burdens for providers otherwise eligible could be in danger of not receiving funding through this new program. 7

Interagency Collaboration

The American Recovery and Reinvestment Act (ARRA) established the Broadband USA program. This program, administered jointly through the U.S. Department of Agriculture (USDA) and the U.S. Department of Commerce, will provide $7.2 billion in funding to expand broadband access across the country.[1]

We urge the Commission to collaborate with the USDA and Commerce, as well as other entities such as HHS, and the Veterans Administration (VA), to form an interagency committee aimed at reducing duplicative efforts and building on separate but overlapping areas of expertise within various health technology and broadband programs. We are confident such an effort would help each agency develop a widespread understanding of individual issues dealing with broadband and health IT, which often overlap amongst the various jurisdictions within the Administration.

Broadband Services Program

While we do have concerns with the broadband infrastructure program as it is currently proposed, the NRHA is supportive of the NPRM's proposed Broadband Service Program intended to replace the Commission's current Internet Access Program. This program, recommended as part of the National Broadband Plan, would provide support to eligible rural health care providers for the recurring costs of access to advanced telecommunications and information services by expanding the definition of services funded in the current Internet Access Program; and provide greater support than its current 25 percent subsidy. Though we do offer suggestions below to strengthen the Commission's reach to rural American health care providers, we are confident this program will assist in the overall goal of achieving a fully robust broadband program aimed at increasing connectivity in rural areas and improving patient access.

The utilization of the Internet Access Program is very low, with less than $2 million spent each year nationwide. This NPRM proposes two significant changes to this program, which are as follows:

[1] From: http://www.broadbandusa.gov/

RUS is making loans and grants for broadband infrastructure projects in rural areas via its Broadband Initiatives Program (BIP). For more information about **BIP**, please visit the program web site.

NTIA is providing grants to fund comprehensive broadband infrastructure projects, public computer centers and sustainable broadband adoption projects via its Broadband Technology Opportunities Program (BTOP). For more information about **BTOP**, please visit the program web site. 8

[2] (INSERT Definition of "entirely rural" and states falling under this definition

1.

Change in Monthly Discount. The current Internet Access Program provides a 25 percent flat discount on monthly internet access for rural health providers (50 percent for providers in states that are "entirely rural"[2]). This NPRM **proposes to raise this discount to *50 percent of an eligible provider's*** recurring monthly costs

2.

Expansion of Eligible Services. The services eligible for this discount are expanded to include advanced telecommunications and information services that provide point-to-point connectivity.

The NRHA is supportive and pleased with these changes to and renaming of the current program Internet Services Program, but also suggests the following improvements to the NPRM to ensure this program truly addresses the needs of the rural providers it is intended to support:

Minimum Broadband Speed

The NRPM points out the National Broadband Plan's suggestion that 4 Mbps downstream is the minimum speed necessary for a current solo practitioner to support the deployment of health IT applications today. Naturally, for larger healthcare providers the National Plan's minimum recommendations are raised accordingly.

Though many components contribute to a provider's broadband capability, one significant factor is that some areas simply do not have access to local service providers offering the ability to reach 4 Mbps. In fact, some rural providers struggle simply to meet much lower speeds. Additionally, even if a provider may have such speeds available, the cost of using it in their area may hinder or eliminate their ability to do so. This is evidenced in Minnesota, where a certain larger hospital with two remote clinics wishes to increase its broadband capability for its clinics. The local service provider, however, does not have the equipment necessary to provide this service, and therefore has asked the hospital to help with these costs so both parties will mutually benefit. This investment for the hospital is estimated at $700,000, which is unachievable for the hospital. So, though the hospital *wants* to increase its broadband capacity, it is limited in its capability to do so for reasons out of their control.

Therefore, though the NRHA supports any effort to bring broadband speeds up to the levels needed to drive the advancement of health technology, and though we are confident rural providers *want* to increase their broadband capabilities, we do not believe setting a minimum level as a means for inclusion into this program is a reasonable proposal. 9

We suggest, therefore, that the Commission implement a system that recognizes the capabilities of rural providers by setting a series of graduated rates as goals to achieve by a certain date, such as 2020.

Additionally, we suggest that the Commission develop strategies to assess current actual usage statistics and use subsequent data to drive its policies determining minimum broadband speeds. This would also require a process in which these statistics were periodically updated, as well as a strategy for measuring widely accepted health provider practices, to help the Commission better adjust to changes and measure actual usage trends.

Support Levels

The Commission has proposed, and requested comments on, its plan to increase its subsidy to assist with monthly recurring costs from the current 25 percent to 50 percent. Additionally, the NPRM states that health providers, on average, that applied for the ubran/rural cost difference for eligible telecommunications services under the existing program received a discount equal to 60 percent. Therefore, we suggest that the Commission set a **minimum level of 60 percent for all eligible health providers.**

Additionally, we still remain very concerned about providers serving areas of great need, such as those in Health Professional Shortage Areas (HPSAs). For these providers, a requirement that they provide 50 percent (or 40 percent that would result in the request above for that matter) of these recurring costs could be debilitating. **Therefore, we urge the Commission to adopt a framework intended to address these unique providers serving rural patients by allowing providers in HPSAs a minimum of 85 percent discount.**

Dual Eligibility

While we would understand the Commission's desire to eliminate "double-dipping," of providers receiving funding from this program if they already participate in the Rural Health Care Pilot Program, we do believe that many providers within the Rural Health Pilot would still require assistance with internet access costs. **Therefore, we urge the Commission to not condition eligibility within this program on whether or not a provider was previously eligible for the Rural Health Care Pilot Program.**

Otherwise, if the Commission does include this condition, we urge that a provision allowing for assistance with internet service costs be included in previously-eligible 10

Non-Recurring Charges

Regarding the Commission's proposal for installation charges for broadband connectivity and limitations related to infrastructure and construction charges, we support the inclusion of a portion of the build-out costs within the monthly operating fees for broadband services, contingent on there being no alternative broadband capabilities are otherwise available by any other telecommunications carrier.

Rather than using Universal Service Funding for such a build-out, though, we urge the Commission to coordinate with the Department of Agriculture (Rural Utilities Service(RUS)) and the Department of Commerce (National Telecommunications Information Administration (NTIA)), to develop ways in which their ARRA-funded broadband programs could provide this funding.

$400 Million Ceiling

The Commission asks for comment on how, if applicable, to account for a circumstance in which total application amounts for funding exceed the funding available. We would suggest that, in this instance, the Commission place a to-be-determined ceiling on each individual award. We believe this would help the Commission remain consistent in divvying funding and ensuring a greater number of awardees. 11

Meaningful Use

The NPRM asks for comment on whether the Commission should tie these programs to the Centers for Medicare and Medicaid Services (CMS) Meaningful Use electronic health record (EHR) guidelines. In rural America, achieving full compliance with the meaningful use standards is a lofty but important goal. Rural health care providers face significant difficulties associated with the current rural workforce shortage, reimbursement inequities, and an overall lack of access to capital. These existing problems, then, only serve to enhance the added costs and staffing burdens of becoming fully compliant with CMS' Meaningful Use guidelines. Furthermore, a provider's ability to achieve Meaningful Use is significantly contingent on its access to a broadband network capable of exchanging information. The mere foundation for Meaningful Use guidelines assumes this capability, and many rural providers are not currently at broadband levels necessary to achieve final Meaningful Use guidelines.

So while a robust electronic health record, telemedicine, and overall health IT framework is a key component of addressing many of the problems rural providers face, the foundation for doing so rests solely on their access to integrated broadband networks.

Therefore, while the NRHA fully supports an eventual tie-in between broadband and meaningful use, we cannot support doing so before this large-scale program truly recognizes the unique broadband and other technological needs and similar needs of rural providers. This would create a double penalty and ensure that non-meaningful users would likely never come into compliance. Eliminating the ability of a provider to receive broadband service would only hinder their ability to meet Meaningful Use guidelines. This provision could end up contributing to the closing of small hospitals that are near a death spiral and must be rejected.

Additionally, as the Commission recognizes in the NPRM, some providers eligible for these new programs are not eligible under CMS' Meaningful Use requirements. Aligning broadband program eligibility to Meaningful Use would likely amount to barriers in eligibility for Skilled nursing facilities, community mental health centers, and entities otherwise eligible for the Commission's broadband programs.

Further, we do not believe Meaningful Use is an applicable measurement to determine the success of the programs proposed in this NPRM. While Meaningful Use compliance is contingent on a system in which sufficient broadband capacity is available to health providers and is specific to electronic health records, broadband service does not conversely rely on a fully adopted EHR system. While integrating broadband service programs and CMS' Meaningful Use guidelines are important, a better measure of 12

actual success within any proposed broadband program would be using the broader concept of a health information exchange.

Health Information Exchange

As stated above, while we believe Meaningful Use and broadband programs should coordinate on a level that fosters overall adoption of both, we do not believe eligibility for, and measurement for success of, the two should be integrated.

A better measure would be integrating broadband programs with the greater concept of the Health Information Exchange (HIE). HIE, which is an effort develop strategies for the greater concept of mobilizing electronic health information across the wider range of hospitals, health networks, regions, or communities, represents a much more realistic means for measuring broadband achievability standards and success. Increasing quality, streamlining care and bringing down overall health care costs are shared goals of both HIE and these proposed broadband programs.

Rural Broadband Evaluation Form

We believe that evaluation measures should be clearly focused on the extent to which fund recipients are utilizing the subsidized broadband for healthcare related purposes, whether or not these purposes add up to comprehensive meaningful use. The Commission should consider developing an evaluation form that elicits detailed information on how the broadband is being utilized to benefit the provider's patients, whether that is for teleradiology (which allows for the expedited remote reading of radiology studies), telemedicine (which allows for remote consultations), accessing electronic health records (which may or may not equate to meaningful use), or other beneficial purposes. 13

Alleviating Administrative Burdens

To alleviate the administrative burden within these proposed or any other FCC programs, we suggest the following:

Relax Yearly Filing Requirements

Current FCC Rural Health Care Program participants must re-apply and re-certify each year to continue receiving benefits. For rural health providers who often have trouble retaining staff to even perform normal paperwork functions, this creates a significant burden. Further, because there are rarely circumstances in which a provider's circumstances change, we believe an annual requirement represents unnecessary burden placed on rural providers. **Therefore, we suggest that this process be moved from an annual requirement to one that requires providers to re-apply and re-certify every three years.**

If in fact the Commission is concerned that this may not be the case, we therefore suggest it conduct a review of applications submitted by single providers over the course of multiple years to analyze any significant changes from year-to-year. We are confident that findings after such a review will reaffirm our point above.

Address complicated application process

A provision within the legislative text authorizing the Rural Health Care Pilot Program requires that reimbursement be equal to the difference between rates for services provided to health providers for rural areas within a state and the rates for similar services provided to other customers in comparable rural areas within that same state. We support this provision, but a formula or method for measuring this required reimbursement has never been developed. Therefore, to receive this benefit, providers are required to navigate the process of developing and posting bids, filing certification forms, and overseeing any other administrative responsibilities associated with proving it meets the program's conditions. **This has proven extremely onerous for rural health providers, and we, along with other similar entities and individual providers, believe that this is a key reason the program has not met expectations since its inception. We therefore suggest such a formula be developed.** 14

[3] Under the current law (Section 254(h)(7)(B)) an eligible entity must fall under one or more of the following categories:

1. post-secondary educational institutions

2. community health centers of health centers providing care to migrants

3. local health departments or agencies

4. community mental health centers

5. not-for-profit hospitals

6. rural health clinics

7. consotria of health care providers consisting of one or more entities described in clauses (1) through (6).

[4] While many CAHs would qualify under these guidelines, many are for-profit entities that are by definition the only hospital in its area. Therefore, we urge the Commission to specifically include these providers to eliminate any confusion.

[5] " "

Eligible Providers

The NRHA greatly appreciates the Commission reexamining its interpretation of current statute to expand its list of eligible providers currently established in law at 224(h)(7)(B).[3] We agree that skilled nursing facilities, renal dialysis centers, administrative offices, and off-site data centers do fall within the currently defined list of eligible providers that are "integral in the delivery of care in the United States." We do suggest that the Commission work, whether by supporting Congressional legislative action or by further extending its efforts to reinterpret current statute, to further expand this definition to include other important providers, such as emergency medical service (EMS) providers operating independently of hospitals, home health providers, residential mental health facilities, individual physician and practitioners' offices, and critical access hospitals (CAH).[4]

EMS services, for instance, would qualify as "local health agencies" (third clause of 254(h)(7)(B), residential mental health facilities as "community mental health centers" (fourth clause), and CAHs as "not-for-profit hospitals" (fifth clause).[5]

We urge the Commission to state additional specific providers to eliminate any question of their eligibility after the fact, but also retain the ability for any further interpretation using the clauses within 254(h)(7)(B). 15

Aligning Quality with Eligibility

The NRHA believes that ensuring and enhancing quality standards in rural America is the most important aspect in delivering healthcare. In recent years we have seen significant overall gains in quality resulting from the implementation of initiatives and programs creating such initiatives. Examples of such initiatives are the implementation of Hospital Compare, a tool used to measure the quality of care amongst various hospitals using a series of quality measures, and programs run through the Medicaid program focused on evidence-based care and quality improvement. Improving quality is a result of a robust health technology system that is founded on an available broadband network, and therefore aligning this NPRM's proposed programs with tools, such as Hospital Compare, would assist in achieving the goals set forth in any efforts aimed at improving overall health care quality. We suggest that the Commission coordinate with the Centers for Medicare and Medicaid Services (CMS) to work towards these goals to improve overall quality.

Lowering Costs and Ensuring Competition

The NRHA supports the needs and benefits of lowering broadband costs by encouraging competition for any program between various telecommunications providers. A system in which competitive bidding is implemented would help achieve this. Additionally, developing strategies that ensure any program's guidelines are followed while also allowing both for- and non-profit providers to compete would help ensure lower costs and quality of service. Additionally, we hope the Commission will work toward policies ensuring choice between service that is wireless, wired or a combination of both. Both of these recommendations would allow providers to choose options best suited for their individual needs. 16

For-Profit Health Care Providers

The NRHA understands and appreciates Congressional intent to limit the definition under 254(h)(7)(B) to only include public and non-profit providers. In rural America, however, a choice between a for-profit and a public or non-profit provider is not always available. In some communities, a for-profit hospital is the only means for accessing health care services within a reasonable distance from one's home. So though certain providers do not fall under the non-profit designation, many in rural areas are the only place to turn for care.

A previous regulatory effort (WC Docket No. 02-60, FCC 03-288, adopted November 13, 2003) in which Commission issued a modification of its rules to "…improve the effectiveness of the rural health care support mechanism" addressed these concerns by recognizing the critical services emergency departments provide regardless of their tax status.

In the prior regulation, the Commission stated that, because of the access barriers to health care services in rural America, certain for-profit emergency departments represented the only means of accessing care within certain communities. For this reason, the Commission determined that for the purposes of its rural health care support mechanism, it was within the scope of Congressional intent to group certain for-profit emergency departments into the definition of non-profit or public health providers.

We therefore urge the Commission to reexamine these previous efforts and develop policies intended to address the same access barriers faced by rural American health providers and patients with a similar effort. If the Commission is interested in such an effort, the NRHA would be pleased to offer any assistance in developing a framework that would recognize Congressional intent of this law, while at the same time protecting its integrity. 17

Final Comments

In conclusion, the NRHA greatly appreciates the Commission's willingness to help bring widespread broadband access to rural America's health providers. Though we have expressed some significant suggestions for improvement, we believe this proposed rule represents a step in the right direction for rural broadband, and we look forward to our continued collaboration.

Thank you again for the chance to offer comments on this proposed rule, and for your consideration on our comments. We very much look forward to continuing our work together to ensure our mutual goal of improving quality of and access to care for all rural Americans. If you would like additional information, please contact Danny Fernandez, NRHA Government Affairs Manager, at Fernandez@NRHArural.org, or 202-639-0550.

Sincerely,

Dennis Berens
President
National Rural Health Association